

# Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: M  F

- Are you under the care of a physician for any reason? Y  N  Reason: \_\_\_\_\_
- When was your last physical exam with your physician? \_\_\_\_\_ If a woman, are you pregnant? Y  Due date? \_\_\_\_\_
- Do you need antibiotics prior to receiving dental care? Y  N  Reason: \_\_\_\_\_
- Please list any major hospitalizations, surgeries and blood transfusions starting with most recent:

Date	Reason	Leave Blank for Doctors Notes

5. Do you have, or have you ever had, any of the following conditions?

Any type of heart disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>	Tumor <input type="checkbox"/> or Cancer <input type="checkbox"/>	N <input type="checkbox"/>
Heart attack	Y <input type="checkbox"/> N <input type="checkbox"/>	-List year diagnosed		-List type	
-List year of attack		-List last HbA1c value		-List year diagnosed	
Angina (chest pain)	Y <input type="checkbox"/> N <input type="checkbox"/>	-List last HbA1c date taken		Radiation treatment	Y <input type="checkbox"/> N <input type="checkbox"/>
Pacemaker	Y <input type="checkbox"/> N <input type="checkbox"/>	Kidney disease	Y <input type="checkbox"/> N <input type="checkbox"/>	-List area treated	
-List year placed		-List year diagnosed		-List year of treatment	
Artificial heart prosthesis	Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis <input type="checkbox"/> or Liver disease <input type="checkbox"/>	N <input type="checkbox"/>	Leukemia <input type="checkbox"/> or Lymphoma <input type="checkbox"/>	N <input type="checkbox"/>
-List year placed		-List type of disease		-List type	
High blood pressure	Y <input type="checkbox"/> N <input type="checkbox"/>	-List year diagnosed		-List year diagnosed	
High cholesterol	Y <input type="checkbox"/> N <input type="checkbox"/>	Viral infections	Y <input type="checkbox"/> N <input type="checkbox"/>	Osteoporosis	Y <input type="checkbox"/> N <input type="checkbox"/>
Stroke	Y <input type="checkbox"/> N <input type="checkbox"/>	-List type of infection		-List year diagnosed	
-List year of event		-List year diagnosed		Artificial joint	Y <input type="checkbox"/> N <input type="checkbox"/>
Anemia <input type="checkbox"/> or other blood disorder <input type="checkbox"/>	N <input type="checkbox"/>	Cold sores/Mouth sores	Y <input type="checkbox"/> N <input type="checkbox"/>	-List year of replacement	
Prolonged bleeding	Y <input type="checkbox"/> N <input type="checkbox"/>	-List frequency of sores		-List joint (s)	
Bruise easily	Y <input type="checkbox"/> N <input type="checkbox"/>	HIV <input type="checkbox"/> or AIDS <input type="checkbox"/>	N <input type="checkbox"/>	Epilepsy <input type="checkbox"/> , fainting <input type="checkbox"/> seizures <input type="checkbox"/>	N <input type="checkbox"/>
Stomach <input type="checkbox"/> or Duodenal <input type="checkbox"/> ulcer	N <input type="checkbox"/>	-List year diagnosed		-List date of last episode	
-List year of diagnosis		Rheumatoid arthritis	Y <input type="checkbox"/> N <input type="checkbox"/>	Sinus Problems	Y <input type="checkbox"/> N <input type="checkbox"/>
Reflux, heartburn, indigestion	Y <input type="checkbox"/> N <input type="checkbox"/>	-List year diagnosed		Asthma	Y <input type="checkbox"/> N <input type="checkbox"/>
Irritable bowel <input type="checkbox"/> or Colitis <input type="checkbox"/>	N <input type="checkbox"/>	Lupus <input type="checkbox"/> or Sjogren's <input type="checkbox"/>	N <input type="checkbox"/>	-List year diagnosed	
-List year diagnosed		-List year diagnosed		Bronchitis <input type="checkbox"/> or Emphysema <input type="checkbox"/>	N <input type="checkbox"/>
Skin disease	Y <input type="checkbox"/> N <input type="checkbox"/>	Immunosuppressive disease	Y <input type="checkbox"/> N <input type="checkbox"/>	-List year diagnosed	
-List type		-List disease type		Mouth breather <input type="checkbox"/> or Snore <input type="checkbox"/>	N <input type="checkbox"/>
-List year diagnosed		-List year diagnosed			
Depression <input type="checkbox"/> or Mental illness <input type="checkbox"/>	N <input type="checkbox"/>	Thyroid <input type="checkbox"/> or Parathyroid issue <input type="checkbox"/>	N <input type="checkbox"/>	Tuberculosis	Y <input type="checkbox"/> N <input type="checkbox"/>
-List year diagnosed		-List year diagnosed		Glaucoma	Y <input type="checkbox"/> N <input type="checkbox"/>

- Are there any other conditions you have that are not listed above? \_\_\_\_\_
- Do you currently  or have you ever  smoked  or chewed  tobacco? N  a. How many packs/cans per day? \_\_\_\_\_  
b. For how many years? \_\_\_\_\_ c. When did you quit? \_\_\_\_\_ d. Where in the mouth do you keep the chew? \_\_\_\_\_
- Have you ever tried to quit? Y  N  a. Using which methods? \_\_\_\_\_ b. Are you interested in quitting? Y  N
- Do you currently have  or have you ever had  an alcohol  or drug  addiction? N  Explain: \_\_\_\_\_
- Please list any medications (prescription or over the counter) you are taking: Check here if not taking any medications

Name	For what condition	Dosage	Year Started

- Have you ever taken Bisphosphonates like Fosamax , Reclast , Actonel , Boniva , Aredia , Zometa , or Prolia ? N   
a. How long ago did you stop? \_\_\_\_\_ b. For how long did you take it? \_\_\_\_\_

12. Please list any allergic or adverse reactions to any drugs (novocaines, penicillin, sulfa, etc)? Check here if no known allergies

Drug	Type of reaction	Doctors Remarks

## Dental History

### Chief Complaint:

1. What is your reason for coming in today? \_\_\_\_\_
2. How long has this been an issue? \_\_\_\_\_ What treatments have you had for this? \_\_\_\_\_
3. Are you currently in pain? Y  N  Explain: \_\_\_\_\_
4. Whom may we thank for your referral to us? \_\_\_\_\_

### Personal History:

5. What is your dentist's name? \_\_\_\_\_ How long have you been a patient there? \_\_\_\_\_
6. Have you had regular dental care? Y  N  When was your last visit to the dentist? \_\_\_\_\_
7. How often do you get cleanings from the dentist? \_\_\_\_\_ How long ago was your last dental cleaning? \_\_\_\_\_
8. Are you fearful of dental treatment? Y  N  Explain: \_\_\_\_\_
9. Have you ever had trouble getting numb / had reactions to local anesthetic? Y  N  Describe? \_\_\_\_\_

### Periodontal History:

10. When was your last deep cleaning with numbing? \_\_\_\_\_ a. Was it for the whole mouth , or which part? \_\_\_\_\_
11. Have you ever been told you have periodontitis? Y  N  When? \_\_\_\_\_
12. How often do you brush your teeth? \_\_\_\_\_ a. Is your toothbrush manual , or powered ?  
b. If powered, which brand? \_\_\_\_\_ c. How long have you used it? \_\_\_\_\_  
d. What kind of toothpaste do you use? \_\_\_\_\_
13. How often do you floss? \_\_\_\_\_ a. If infrequently, do you floss the whole mouth  or which part? \_\_\_\_\_  
b. Do you use other cleaning aids such as proxybrush , Waterpik , or other: \_\_\_\_\_  
c. How often do you use these other aids? \_\_\_\_\_ d. How long have you used these other cleaning aids? \_\_\_\_\_  
e. Do you use them in the whole mouth , or which part? \_\_\_\_\_
14. Which brand of mouth rinse do you use? \_\_\_\_\_ b. How often? \_\_\_\_\_ c. Since when? \_\_\_\_\_
15. Do you have daytime dry mouth? Y  N  a. Which cause? \_\_\_\_\_ b. How treated? \_\_\_\_\_
16. Have you had cavities in the past 3 years? Y  N  b. Besides fillings, any fluoride  or dietary changes  implemented?

### Jaw and Bite:

17. Do you clench  or grind  your teeth during the day  or at night ? N  a. If at night, do you know you do because:  
a. Your dentist told you , b. Your teeth  or jaws  are sore in the morning, c. Other \_\_\_\_\_
18. Do you wear a bite guard during the day  or at night ? N  b. How often? \_\_\_\_\_  
c. Is the guard from your dentist , or the grocery store ? d. How long have you used it? \_\_\_\_\_
19. Do you wear a sleep appliance  or CPAP on your nose  or whole mouth ? N  a. What year did you start? \_\_\_\_\_  
b. How often do you use it? \_\_\_\_\_ c. Have you ever had a sleep study? Y  N  When? \_\_\_\_\_
20. Do you have problems with your jaw joints: N , pain , sounds , limited opening , locking , popping , headaches   
a. Which joints? Right , Left  b. How often do you have the joint problems? \_\_\_\_\_  
c. Have you seen a TMJ specialist in the past? Y  N  d. Who did you see and when? \_\_\_\_\_
21. Have your teeth changed in the past 5 years: N , become shorter , worn , broken , cracked , crowded , spaced
22. Have you ever had orthodontics (braces)? Y  N  a. Who was/is your orthodontist: \_\_\_\_\_  
b. When did  or When will  you complete treatment? \_\_\_\_\_

### Your Thoughts:

Are there any other comments or questions you have? \_\_\_\_\_

By signing below, I acknowledge that I filled out this form to the best of my knowledge, and that I am the person that filled out this form.

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Nicoara's Signature: \_\_\_\_\_ Date: \_\_\_\_\_